STATE OF MICHIGAN
IN THE SUPREME COURT

Appeal from the Michigan Court of Appeals
Hon. Michael R. Smolenski, Presiding Justice

WEXFORD MEDICAL GROUP,

Petitioner-Appellant, Supreme Court No. 127152

v Court of Appeals No. 250197

CITY OF CADILLAC, Michigan Tax Tribunal No. 276304

Respondent-Appellee.
_____/

BRIEF OF MICHIGAN RURAL HEALTH CLINICS ORGANIZATION AS AMICUS CURIAE IN SUPPORT OF PETITIONERS-APPELLANTS

E. WILLIAM SHIPMAN (P36143)
Attorney for Amicus Curiae
Michigan Rural Health Clinics Organization
Butzel Long, P.C.
150 W. Jefferson Avenue, Suite 100
Detroit, MI 48226
(313) 983-7461

JOHN D. PIRICH (P23204)
STEWART L. MANDELL (P33781)
Attorneys for Petitioner-Appellant
Wexford Medical Group
Honigman Miller Schwartz and Cohn LLP
222 North Washington Square, Suite 400
Lansing, MI 48933
(517) 377-0712
(313) 465-7420

DAVID S. MCCURDY (P24095)
ROGER WOTILA (P22561)
CYNTHIA WOTILA (P36043)
Attorneys for Respondent-Appellee
City of Cadillac
McCurdy & Wotila, PC
120 West Harris Street
Cadillac, MI 49601
(231) 775-1391

TABLE OF CONTENTS

INDEX OF AUTHORITIES

Cases

Statutes

Other Authorities

Guide to Clinical Preventive Services, 2d Ed. (Washington, D.C.: U.S. Preventive Services Task Force, U.S. Dept. of Health and Human Services, 1996) 21

Lester, *MSMS MD Data Survey Documents Medical Trends*, 96 Michigan Medicine 18 (May, 1997) ... 11, 26

Monthly Top Ten: Survey Says ... Medicaid Will Lose More Physicians (Lansing, MI: Michigan State Medical Society, June 2005) 10

Novak, *2005 MSMS Physician Data Survey on Practice Characteristics*, 104 Michigan Medicine 8 (May/June 2005) 11, 25, 26

Putnam, *Doctors call for Medicaid increase* (Lansing, MI: Michigan Live, State Edition, Feb. 3, 2000) 10

Ramirez, *To get healthy, Medicaid needs money* (Grand Rapids, MI: Michigan Live, Grand Rapids Edition, Feb 28, 2000) 10

Sia, Tonniges, Osterhaus & Taba, *History of the Medical Home Concept*, 114 Pediatrics 1473, 1473 (May , 2004) 25

Survey shows fewer doctors treat Medicaid patients, (Detroit, MI: Detroit Free Press, freep edition, May 26, 2005) 10, 11

Wendland-Bowyer, *A Sick Kid's Only Hope* (Detroit, MI: Detroit Free Press, May 19, 2000) 12

Ziller, Coburn, Loux, Hoffman & McBride, *Health Insurance Coverage in Rural America* (Washington, D.C.: Institute for Health Policy and the Kaiser Commission on Medicaid and the Uninsured, Sept. 2003). 9, 11, 12

Zuckerman, McFeeters, Cunningham & Nichols, *Changes In Medicaid Physician Fees, 1998-2003: Implications For Physician Participation* (Bethesda, MD: Health Affairs, June 23, 2004) 11

STATEMENT OF AUTHORITY FOR FILING AMICUS CURIAE BRIEF

In an Order issued May 12, 2005, this Supreme Court granted the motion of the Michigan Rural Health Clinics Organization ("MRHCO") to file a brief amicus curiae in this matter. MRHCO is a Michigan nonprofit corporation which was formed to assist rural health clinics in Michigan provide cost-effective health care in underserved rural areas. MRCHO sought to provide input in this case because it believes access to healthcare in rural areas, which is already limited, will be further impaired if property tax exemption is denied in the instant case.

STATEMENT OF QUESTIONS INOLVED

A. Has the Petitioner, Wexford Medical Group ("Wexford"), demonstrated that it is entitled to the charitable institution exemption set forth in MCL 211.7o (for real and personal property) and MCL 211.9(a) (for personal property)?

B. Has Wexford shown that it is entitled to the public health exemption under MCL 211.7r?

C. May the Tax Tribunal or the judiciary impose a threshold level of charitable care or public health services when the Legislature has not done so?

SUMMARY STATEMENT OF FACTS

This dispute concerns whether certain property (the "Property") owned and used by Wexford in the operation of a medical facility (the "Clinic") in Cadillac, Michigan, is entitled to property tax exemption under MCL 211.7o or MCL 211.9(a) (collectively, the "Charitable Exemption") and/or MCL 211.7r (the "Public Health Exemption").

Wexford is a Michigan nonprofit corporation which is exempt from federal income tax pursuant to 26 USC 501(c)(3), Section 501(c)(3) of the Internal Revenue Code of 1986, as amended (the "Code").

Wexford is a joint venture of Munson Healthcare of Traverse City ("Munson") and Trinity Health of Novi, Michigan ("Trinity"), both of which are tax-exempt public charities under Code Section 501(c)(3). Wexford, Munson and Trinity share a similar charitable mission of promoting the health of the community by providing healthcare to members of the community, including persons who are poor or in underserved areas, such as Cadillac, which is a federally-designated health professional shortage area. In furtherance of these missions, the Munson and Trinity healthcare systems, including Wexford, have provided millions of dollars of charitable healthcare over the years.

The Clinic operated by Wexford, unlike most other healthcare providers in the area, provides medical care to all patients regardless of their source of payment or ability to pay, and, accordingly, provides substantial care to Medicaid and Medicare patients. Generally, the cost of delivering care to Medicaid and Medicare patients exceeds government reimbursements for such care. In addition, Wexford offers qualifying patients a charity care program and provides numerous free or low cost healthcare services to the community, such as community health fairs, health screenings and educational presentations.

Wexford, like some other medical practices, treats a variety of medical conditions ranging from acute and contagious conditions like hepatitis, meningitis, HIV, AIDS and tuberculosis, to other severe maladies such as diabetes, obesity, congestive heart failure and chronic pulmonary disease, to non-acute illnesses such as earaches, sore throats and colds. Its services include activities which should be characterized as public health care services, including the control of communicable diseases, preventative medicine, and health education.

The City of Cadillac rejected Wexford's claim of exemption. The Michigan Tax Tribunal (in Wexford Medical Group v City of Cadillac, MTT Docket No. 276304 (July 17, 2003) (attached as Exhibit A) and Court of Appeals (in Wexford Medical Group v City of Cadillac, Unpublished opinion, COA

Docket No. 250197 (Aug. 24, 2004) (attached as Exhibit B) affirmed the City of Cadillac. Wexford applied to the Supreme Court for leave, which this Court granted on May 12, 2005.

ARGUMENTS

A. INTRODUCTION

Michigan law provides property tax exemption for property which is owned and occupied by qualifying nonprofit entities for charitable purposes (MCL 211.7o and MCL 211.9(a)) or public health purposes (MCL 211.7r). As discussed below, the Property qualifies for exemption under both of these statutory exemptions.

The Charitable Exemption applies because Wexford makes a gift to the community by providing, at a loss, guaranteed access to care and by providing free and under-compensated services to the community. In particular, Wexford's acceptance, without limitation, of Medicaid patients, in return for inadequate payments, constitutes charity.

The Public Health Exemption also applies. Wexford is truly public since it makes available care to all members of the community without regard to their source or ability to pay. The Clinic is a vital component of the public health system, which, in this country, includes both governmental and non-governmental providers. Its services, including immunization, communicable disease control, health screening and patient education, are indisputably public health activities; the mere fact that Wexford is not a governmental entity does not change this.

This case is important for all non-profit clinics in the State, and especially for clinics serving rural communities. Rural areas often suffer from limited access to health care and often have difficulty attracting and retaining health care providers. In addition, rural populations tend to be less affluent than metropolitan populations, which results in rural residents relying heavily on Medicaid for health

care coverage. Many rural providers generate lower revenues than their metropolitan counterparts, making their viability particularly sensitive to the containment of costs not directly related to the provision of health care. Rejecting Wexford's exemption claim will increase those costs and thereby provide a further disincentive for the establishment and maintenance of non-profit clinics in rural communities. Given the problems rural communities already face in securing care, rejection of Wexford's exemption claim could have very severe consequences.

B. CHARITABLE EXEMPTION

MCL 211.7o(1) provides:

> Property owned and occupied by a nonprofit charitable institution while occupied by a nonprofit charitable institutions solely for the purposes for which it was incorporated is exempt from the collection of taxes under this act.

MCL 211.7o establishes a three-part test for exemption. First, the property must be "owned and occupied" by the claimant. This is not disputed in the Wexford case. Second, the claimant must be a "nonprofit charitable institution". Third, the property must be used "solely for the purposes for which [the applicant] was incorporated". Here, each test is met.

1. **Construction of Charitable Exemption**. While Michigan courts state that exemptions are to be narrowly construed against the claimant, as applied, the definition of "charitable" for the exemption has been broad. In Community Emergency Medical Service, Inc. v Novi, MTT Docket No. 126009 (Sept. 15, 1994) ("CEMS"), the Tribunal stated that "charitable" has a broad meaning:

> Appellate courts purport to pay homage to the time-honored rule of strict construction of exemption statute in favor of the taxing authority ... However, the practical reality is that 'when used in reference to tax exemptions, the word "charitable" has a much broader meaning than that commonly associated with the word.' Kalamazoo Aviation History Museum v City of Kalamazoo, 131 Mich App 709, 715; 346 NW 2d 862 (1984). ... [T]he concept of 'charity' [must be viewed] from a judicially-approved, "more expansive", perspective" Edsel &

> Eleanor Ford House v Village of Grosse Pointe Shores, 134 Mich App 448, 457-8; 350 NW 2d 894 (1984).

A similar sentiment was expressed in National Music Camp v Green Lake Twp, 76 Mich App 608, 612; 257 NW2d 188 (1977) where the court stated that "A liberal and not a harsh or strained construction is to be given to the term ... 'charitable'".

2. **Charitable Institution**. The question of whether an entity is a "charitable institution" was considered in Gull Lake Bible Conference Ass'n v Ross Twp, 351 Mich 269, 274; 88 NW2d 264 (1958), as the first step in determining whether a charitable exemption was available. In considering the question, the Court relied solely upon the *form* or *organizational structure* of the entity:

> The plaintiff corporation is organized as a nonprofit corporation. The proofs show conclusively that it is not operated for profit. It has no stockholders. Aside from modest salaries paid necessary employees, no individual receives any pecuniary benefit from its operation. It practices do discrimination as to race, creed or color. Having in mind the purposes for which it was formed as set forth in article 2 of its articles of association, the conclusion is inescapable that it is a charitable organization and such is the decision of this court.

In Huron Residential Services for Youth, Inc. v Pittsfield Twp, 152 Mich App 54; 393 NW2d 568 (1986), the court held that property used by a nonprofit corporation to rehabilitate troubled youth was exempt under the charitable exemption. The court first stated that the exemption statute created two requirements, the first was whether the "institution be charitable", and the second whether it "occup[ied] the property solely for the purposes for which it was incorporated." The court distinguished the two requirements. Huron Residential, 152 Mich App at 60. In finding that the claimant was a "charitable institution", the court quoted Auditor General v R.B. Smith Memorial Hospital Ass'n, 290 Mich 36; 291 NW 213 (1940):

> In general it may be stated that any body not organized for profit, which has as its purpose the promotion of the general welfare of the public, extending its benefits without discrimination as to race, color, or creed, is a charitable or benevolent organization within the meaning of tax exemption statutes. Huron Residential, 152 Mich App at 60-61.

In construing the exemption in this way, the Court adopted a test similar to that employed by the Internal Revenue Service in determining whether entities are entitled to charitable exemption under Code Section 501(c)(3). Treasury Regulation ("Reg") Section 1.501(c)(3)-1(a) expressly establishes an "organizational test" which is separate and distinct from the "operational test." Like the courts in Gull Lake, Auditor General and Huron Residential, the IRS has bifurcated its analysis to aid decision-making. The question of whether a corporation is a charitable institution for purposes of MCL 211.7o , therefore, is resolved by looking to the corporation's organization, not by looking at its activities.

Michigan nonprofit corporations are subject to numerous restrictions which operate to ensure such entities operate for the public good and not for private purposes. For example, under MCL 450.2108(3), the purpose of a nonprofit corporation may not involve "pecuniary gain" for its directors, officers, shareholders or members, and under MCL 450.2301(5) and MCL 450.2855 assets held for charitable purposes may not be conveyed for noncharitable purposes. Under MCL 14.251, the State Attorney General has the power to enforce the charitable articles in the charters of nonprofit corporations, and has exercised this power. See, e.g., Attorney General v. Michigan Affiliated Healthcare System, Inc., Unpublished opinion, Ingham Circuit Court, Docket No. 96-83848-C. Z. (January 3, 1997) (attached as Exhibit C).

Wexford, as indicated in its Articles of Incorporation is a nonprofit corporation which qualifies as a "charitable institution" within the meaning of MCL 211.7o, organized to promote health. Wexford's nonprofit status, with all of the restrictions inherent therein, provides a basic assurance that Wexford will operate to further the public good, and not to enrich any "insiders."

3. **Used For Charitable Purpose**. The major issue is whether the Clinic uses the Property for "charitable purposes." Michigan courts have held that "Charity ... is a gift, to be applied consistently

with existing laws, for the benefit of an indefinite number of persons, ... by relieving their bodies from disease, suffering, or constraint... or ... lessening the burdens of government". Retirement Homes of the United Methodist Church, Inc. v Sylvan Twp, 416 Mich 340, 348-349; 330 NW2d 682 (1982); Edsel & Eleanor Ford House v Grosse Point Shores, 134 Mich App 448, 457; 350 NW 2d 894 (1984). To be operated for charitable purposes within the meaning of Michigan law, then, the Clinic must meet three tests: (a) the Clinic's operation must relieve bodies from disease, suffering, or constraint, or lessen the burdens of government (it seems clear the Clinic relieves bodies of distress as required); (b) the Clinic's operation must be conducted consistently with existing laws (this is undisputed); and (c) the Clinic's operation must provide a "gift" to an indefinite number of persons.

The most contentious issue in applying the charitable exemption in the context of health care concerns whether a "gift" is made. Here, as discussed below, even though Wexford generally charges for services rendered at the Clinic, it does make a valuable gift to the community, and it makes this gift to an indefinite number of people.

(a) **Charges Not Inconsistent With Exemption**. The mere fact that an organization charges for its services does not mean there can be no gift. Charitable entities may charge for services. *See, e.g.*, Retirement Homes, 416 Mich at 350, note 15 ("a nonprofit corporation will not be disqualified for a charitable exemption because it charges those who can afford to pay for services as long as the charges approximate the cost of the services".); Michigan Sanitarium & Benevolent Ass'n v Battle Creek, 138 Mich 676; 101 NW 855 (1904) (hospital exempt as being "sufficiently charitable" even though "apparently most of [its patients] paid a regular schedule of prices fixed by management."); Auditor General, 293 Mich at 39 ("the fact that a charge is made for benefits conferred, against those who are able to pay, in no way detracts from the charitable character of an organization"); Gull Lake, 351 Mich at 274

(quoting Auditor General, "the fact that a charge is made for benefits conferred, against those who are able to pay, in no way detracts from the charitable character of an organization") and CEMS.

Note 15 in Retirement Homes, 416 Mich at 350, suggests that charges should "approximate the cost of services", while other passages in Retirement Homes, as well as in Michigan Sanitarium and Auditor General focus on the related concept of whether the charges are more than is necessary to for the organization's successful maintenance. In CEMS, the Tribunal declined to compare charges to services on a procedure-by-procedure basis, and instead compared the "ratio of aggregate expenses to aggregate charges collected", and found that the claimant's "revenues fairly approximated its costs since its costs absorbed 90 percent to 99 percent of charges collected in the relevant time."

Here, Wexford is not charging excessively and is not even charging enough to cover its costs. Wexford's charges for services do not preclude exemption.

(b) **Gift: Continuing Service at a Loss**. Wexford provides a gift from the Clinic by continuing to provide a broad range of services even though the compensation for its services does not pay for the costs of operating the Clinic. Despite its continuing losses, Wexford continues to provide a broad range of health care services, and continues to provide such services to all, regardless of their ability to pay.

This access is a gift, and a very important one, especially since the Clinic is located in a rural area. The Cadillac area is a Federally-designated rural healthcare shortage area. Many rural areas suffer similar shortages of healthcare access. Researchers have found that: "Rural communities face challenges maintaining an adequate supply of physicians, nurses, and other health professionals. Although 20% of the U.S. population lives in rural America, only nine percent of physicians practice there." Ziller, Coburn, Loux, Hoffman & McBride, *Health Insurance Coverage in Rural America* (Washington, D.C.:

Institute for Health Policy and the Kaiser Commission on Medicaid and the Uninsured, Sept. 2003), p. 9 (hereafter, "*Coverage in Rural America*") (Attached as Exhibit D).

This limited access to care may have had a significant adverse impact on the health of rural residents. As stated in *Coverage in Rural America*, p. 5, "Rural residents are also less likely to receive recommended preventive care services ... Studies suggest that rural residents' poor access to preventive care may be a function of their poor access to physician care in general."

Access has value in and of itself, especially in a medically underserved rural area. With a limited number of providers, and a limited ability to attract more, the community would suffer if the Clinic closed, or restricted its clientele to those with relatively generous private insurance coverage.

(c) **Gift: Indigent Care.** The Clinic provides care to indigents without regard to their ability to pay. It is true that the amount of indigent care provided under the official charity care policy does not constitute a large percentage of services rendered at the Clinic. Nevertheless, Wexford does adhere to its policy of treating all patients without regard to their ability to pay. In addition, all of the uncompensated care provided at the Clinic is not provided in conjunction with the formal charity care policy; much of such treatment is provided informally, as are arrangements for reduced payments.

It is important, in this regard, to distinguish between providing care and billing for care. Wexford provides care to all who present. After providing care, it may try to collect for services rendered. But Wexford's policies dictate that it always provide the care first, and (if appropriate) seek collection later. This is in stark contrast to what private physician practices may do. A private physician may simply require a patient to pay first, as a condition of receiving care.

In a perfect world, Wexford could provide free care to all who present and claim to have difficulty in paying for their care. Unfortunately, this is not a perfect world, and Wexford has financial obligations it must meet. But the fact that Wexford attempts to obtain payment must not be allowed to

obscure the very real and fundamental difference that exists between Wexford and a private physician: Wexford provides care and (if appropriate) seeks payment later; a private physician may condition the delivery of care on prior payment. While neither system is perfect, it is clear that Wexford's policy is more charitable and beneficial to the community.

(d) **Gift: Medicaid Care.** While Wexford is compensated for care provided to Medicaid patients, the amount of the compensation is below the cost of the services. The poor payment rate of Medicaid is demonstrated by comparing Medicaid payments to the amount billed by physicians, by comparing Medicaid payment rates to Medicare payment rates, and by considering whether Medicaid payments are attractive enough to induce physicians to participate in the program.

At least two news articles have reported Michigan's Medicaid director, Paul Reinhart, as stating that Medicaid reimburses doctors between 30 percent and 40 percent of their customary charge. See, *Monthly Top Ten: Survey Says ... Medicaid Will Lose More Physicians* (Lansing, MI: Michigan State Medical Society, June 2005) (attached as Exhibit E); and *Survey shows fewer doctors treat Medicaid patients*, (Detroit, MI: Detroit Free Press, freep edition, May 26, 2005) (attached as Exhibit F). This rate is consistent with the 31 percent rate cited in other articles. See, e.g., Ramirez, *To get healthy, Medicaid needs money* (Grand Rapids, MI: Michigan Live, Grand Rapids Edition, Feb 28, 2000) (attached as Exhibit G); Putnam, *Doctors call for Medicaid increase* (Lansing, MI: Michigan Live, State Edition, Feb. 3, 2000) (attached as Exhibit H)).

Medicaid payment compares poorly not only to customary physician rates, but also to Medicare payment rates. News articles have noted that, even after a slight increase in payment for Medicaid services, "In 2003, Medicaid fees were 69 percent of Medicare fees, up from 62 percent in 1998 ... Medicaid fees increased to 62 percent of Medicare fees in 2003 for primary care services (up from 56 percent in 1998)." Zuckerman, McFeeters, Cunningham & Nichols, *Changes In Medicaid Physician*

Fees, 1998-2003: Implications For Physician Participation (Bethesda, MD: Health Affairs, June 23, 2004) (attached as Exhibit I). Accordingly, for the same services, primary care physician receive from Medicaid only 56 percent to 62 percent of what they would receive from Medicare. Since Medicare is not excessively generous – there is substantial evidence that the Clinic, with its high participation in Medicare, has operated at a loss for some time, and commentators have noted the "lower payment levels of Medicare and Medicaid" (see *Coverage in Rural America*, p. 7) -- it is apparent that Medicaid reimbursement is very poor.

That Medicaid's payment rate is very low is also indicated by the fact that only 65 percent of State physicians currently participate in Medicaid, down from 88 percent in 1999. *See* Novak, *2005 MSMS Physician Data Survey on Practice Characteristics*, 104 Michigan Medicine 8 (May/June 2005) at p. 15 (hereafter, the "*MSMS 2005 Survey*") (attached as Exhibit J); and *Survey shows fewer doctors treat Medicaid patients*, *supra*. And this downward trend is expected to continue, as 18 percent of physicians surveyed in the *MSMS 2005 Survey*, *supra*, *at p. 12, 16*, said they "do not intend to continue accepting Medicaid patients in the coming year." Moreover, even these low rates overstate participation among "typical" practitioners, since many physicians limit the number of Medicaid patients they will see. According to the Michigan Medical State Society survey, Lester, *MSMS MD Data Survey Documents Medical Trends*, 96 Michigan Medicine 18 (May, 1997) at p. 39 (hereafter, the "*MSMS 1997 Survey*") (attached as Exhibit K) only 58 percent of physicians surveyed accepted new Medicaid patients without limits. In addition, since about 13 percent to 15 percent of physicians work for charitable or governmental institutions that require their physicians to see all Medicaid patients who present (*See MSMS 1997 Survey* at p. 24, and the *MSMS 2005 Survey*, *supra*, at p. 10), it can safely be said that fewer than half of truly private physicians accept new Medicaid patients without limits. That most private practitioners would turn

down patients because they are on Medicaid indicates how poor the payment rates and terms for Medicaid in fact are.

Medicaid is particularly relevant for rural residents, as they are more likely to have Medicaid, as opposed to private insurance, coverage. News articles have highlighted the importance of Medicaid care in rural communities, and how providers provide Medicaid care at a loss. *See, e.g.*, Wendland-Bowyer, *A Sick Kid's Only Hope* (Detroit, MI: Detroit Free Press, May 19, 2000) (attached as Exhibit L), which discusses the last pediatrician in Emmett County to accept new Medicaid patients, and how treatment of Medicaid patients is done at a loss. Researchers have found that Medicaid is an "extremely important" source of coverage for rural residents, "particularly for children" since 30 percent of children in rural areas which are not adjacent to urban areas had coverage through Medicaid (or its offshoot, S-CHIP), compared to 19 percent of children in urban areas or other rural areas. *Coverage in Rural America*, p. 1. For the remote rural population as a whole, Medicaid coverage runs at 16 percent, as opposed to 11 percent for urban areas. *Coverage in Rural America*, p. 12. Recognizing the importance of Medicaid to rural health, researchers noted that "expanding on [the Medicaid base] could be a particularly effective way to increase coverage among the uninsured." *Coverage in Rural America*, p. 3.

Michigan courts have recognized the importance of providing Medicaid care and the inadequacy of payments made by Medicaid. In CEMS, the Tribunal concluded that the claimant provided to the communities it served "significant benefits for which they do not pay, including uncompensated and partially compensated services afforded the indigent and poor". Thus, the Tribunal recognized the inadequacy of Medicaid payment and acknowledged that providing Medicaid services can constitute a gift within the meaning of the charity exemption. Marycrest Manor v City of Livonia, MTT Docket No. 96689 (Aug. 17, 1989) also notes the inadequacy of Medicaid payments. In Marycrest, the Tribunal

awarded charitable exemption to a home for the aged, which housed residents on whose behalf the claimant received payments from Medicaid, stating:

> While it is true that some of the residents receive Medicaid, we conclude that this fact does not negate Appellant's charitable activities. Those residents receiving Medicaid were unable to pay for their own care. The reimbursement provided by Medicaid was insufficient to cover Appellant's costs.

In summary, Medicaid is a critical component of the healthcare system, especially for the poor and those in rural areas, but providers are financially punished for delivering this care. Accordingly, courts have recognized that providers act charitably in rendering Medicaid services. This Court, too, ought to recognize that entities like Wexford, which in contrast to many private providers, offer care to all Medicaid patients who present, should be recognized as providing a valuable gift to the community. This Court should find that Wexford's below cost care to Medicaid patients constitutes charity.

(e) **Gift: Community Activities**. Wexford personnel at the Clinic have undertaken numerous community-oriented health care activities. They have offered screenings for blood pressure and blood sugar and a number of educational programs for school and community groups.

(f) **Gift: Lessening Burdens of Government**. As discussed above, the Clinic, by providing immunizations and otherwise undertaking activities which might otherwise fall to the County or higher cost hospitals, is lessening the burdens of government. This constitutes a gift.

4. **Summary: Charitable Exemption**. Wexford has as its purpose the promotion of health in a charitable manner. Wexford operates charitably. Its medical services relieve individuals of health problems and lessen the burdens the Department of Community Health or local public health department would otherwise absorb. The Clinic provides essential access for members of the community, which is critical in a medically underserved area. It takes all patients regardless of their ability to pay, and treats at a loss numerous Medicaid patients. It also makes a variety of other gifts to the community. While it

charges those who can afford to pay for services, its fees do not cover its expenses and do not preclude exemption.

C. PUBLIC HEALTH EXEMPTION.

MCL 211.7r provides, in relevant part:

> The real estate with the buildings and other property located on the real estate on that acreage owned and occupied by a nonprofit trust and used for hospital or public health purposes is exempt from taxation under this act.

Under MCL 211.7r a claimant must be a "nonprofit trust"; it must "own and occupy" the real estate in question and the real estate must be used for "hospital or public health purposes". Wexford meets these tests.

1. **Nonprofit Trust**. Wexford is a Michigan nonprofit corporation. *See*, In Oakwood Hospital Corp v State Tax Comm., 385 Mich 704, 708; 132 NW2d 634 (1971), the Michigan Supreme Court ruled that the phrase "nonprofit trust" was "broad enough to include nonprofit corporations". As discussed above, due to the restrictions imposed on nonprofit corporations, Wexford's nonprofit status helps ensure it will operate for the public benefit.

2. **Owned And Occupied**. Wexford is the owner of the Property.

3. **Public Health Purposes**. Michigan courts have adopted at least five different methods for determining whether property is used for "public health purposes". These include: (i) An analysis based on whether the Public Health Code applies to a claimant; (ii) An assessment of the activities of governmental public health departments, as compared to the claimant's activities; (iii) An analysis of whether the property is used for "health" purposes and of whether the property is open to the public; (iv) A determination of whether the property is used to protect and improve community health by means of preventative medicine, health education, communicable disease control, and the application of the social

and sanitary sciences; and (v) A determination of whether the asserted public health activities are those of the operation of a "typical family medical practice." These are discussed below.

a. **Public Health Code Analysis.** In Brookcrest Nursing Home v City of Grandville, MTT Docket No. 7720 (Aug. 4, 1986), the Tax Tribunal referred to the Public Health Code in determining that a nursing home subject to regulation under the Public Health Code should also be considered to operate for public health purposes for purposes of taxation:

> [I]t is logical to infer that the legislature intended public health purposes to include those entities that it licenses as public health facilities. *** It would be anomalous and analytically anemic to conclude that a facility regulated for public health services loses its character as such when taxed on the basis of whether it is used for public health purposes.

The Public Health Code deals with the provision of medical care, and Wexford's activities are subject to the Public Health Code. For example, the Wexford physicians and paraprofessionals who treat patients at the Property must be licensed. *See*, MCL 333.17201, MCL 333.17801, MCL 333.17501, and MCL 333.17001. The Clinic is subject to regulations concerning medical waste. *See*, MCL 333.13813.

Note that, while regulation under the Public Health Code may support exemption, in Rose Hill Center, Inc. v Holly Twp, 224 Mich App 28, 33; 568 NW2d 332 (1997), the court expressly rejected the assertion that, to be exempt under MCL 211.7r, a facility must be licensed under the Public Health Code. Accordingly, regulation under the Public Health Code supports exemption, but its absence is not fatal to exemption.

b. **Comparison to Governmental Health Departments.** Clinics like Wexford undertake numerous activities similar to those undertaken by public health departments, including: (i) preventing epidemics and the spread of disease (through immunization, screenings and treatment; (ii) preventing injuries (through patient education and counseling and by reporting certain abuse (as required

by MCL 722.623)); (iii) promoting and encouraging healthy behaviors, such as weight loss and smoking cessation; (iv) assuring the quality and accessibility of health services (through ongoing quality assurance programs); (v) monitoring health status to identify community health problems (as exemplified by Wexford's obligation to report certain diseases and conditions, such as communicable diseases (MCL 333.5111); occupational diseases (MCL 333.5611); and child abuse (MCL 722.623)); (vi) informing, educating, and empowering people about health issues (through educational efforts and counseling); (vii) developing policies and plans that support individual health efforts (through educational efforts and counseling.); (viii) linking people to needed personal health services and assure the provision of health care when otherwise unavailable (through referrals to other providers), and by accepting all patients without regard to their ability to pay; (ix) assuring a competent personal health care workforce (by ongoing quality assessment, including assessment of programs; and (x) evaluating effectiveness, accessibility, and quality of personal health services (through assessment of programs).

Note that numerous entities, ranging from nursing homes to child care centers to purchasing cooperatives, have obtained exemption pursuant to the public health exemption, even though their activities do not remotely compare to those of a government health department. Accordingly, while the provision of services which are similar to those provided by a public health department supports exemption, failure to provide such services is not fatal to exemption.

c. **Promotion of Health + "Open to Public"**. In Brookcrest, *supra*, the Tribunal considered an alternate approach to determine whether a nursing home came within the public health exemption. The Tribunal seemed to divide the analysis into two parts: whether the facility is "used for health purposes"; and "whether the property is used for public, as opposed to private, health purposes". In determining whether a facility is operated for public, as opposed to private, health purposes, the Tribunal said "the focus is on whether the facility will accept members of the general public", and concluded that

Brookcrest was used for public purposes because it did "not discriminate in admission of patients on the basis of race, religion, color, national origin, sex, age, handicap status, marital status or sexual preference." Following this analysis, the Clinic should be considered public health property, since the Property is used to promote health and since Wexford does not discriminate on the basis of race, religion, national origin, sex, age, etc., and Wexford treats all patients, regardless of ability to pay.

Note that the Tribunal found that the Brookcrest claimant could "still be considered as being utilized for public health, even if the members of the public must pay their way to remain in the facility. Indeed, the primary relationship between a hospital and its patients is no different". An identical conclusion was reached in Henry Ford Continuing Care Corp. v City of Roseville, MTT Docket No. 142360 (Nov. 19, 1993), where the Tribunal found that a nursing home, which provided care only to those with the ability to pay, was nevertheless entitled to the public the health exemption.

d. Rose Hill. In Rose Hill, 224 Mich App at 33, the Court of Appeals adopted a definition of "public health" which has been accepted in several cases *See, e.g.*, Butterworth Health Corp. v Gaines Twp, MTT Docket No. 236443 (April 2, 1999), ProMed Healthcare v Kalamazoo, 249 Mich App 490; 644 NW2d 47 (2002), and, at least in form, the instant case. Public health is defined in Rose Hill, 224 Mich App at 33, as:

> ...the art and science of protecting and improving community health by means of preventative medicine, health education, communicable disease control, and the application of the social and sanitary sciences.

Rose Hill thus focuses on whether an institution protects and improves community health by means of: (i) preventative medicine; (ii) health education; (iii) communicable disease control; and (iv) the application of the social and sanitary sciences. The Clinic satisfies the majority of these tests, much more so than other entities which have been accorded exemption under MCL 211.7r.

(i) Community Health. The Rose Hill court did not identify which Rose Hill operations protected and improved community health or what was meant by "community health". However, the court (like the Tribunal in Brookcrest) accepted that the claimant was open "without regard to race, religion, or sex" and accepted patients covered by Medicare and Medicaid. The court considered that an organization must be open to the community to protect and improve community health.

Here, the Court of Appeals concentrated on whether the healthcare provider focused on the "community at large." However, it is clear that this emphasis is miles away from what the Rose Hill court actually meant in using the term. The Court of Appeals in the instant case could not explain why the Rose Hill home for the mentally ill, which served only 30 live-in patients, had as its "central focus" the "community at large", but the Clinic, which has served thousands of patients, did not. The only aspects of the operations of the Rose Hill home that at all suggest that its focus was the community at large are the fact that the Rose Hill home accepted patients covered by Medicaid or Medicaid, and that it accepted adult patients without regard to race religion or sex. So, it seems that, in Rose Hill, the "community health" reference is intended only to ensure that the claimant provides services to a broad segment of the public and does not discriminate on the basis of race, sex or religion.

Under any plausible definition, it is clear that, with its provision of services to members of the public at large, Wexford satisfies the "community health" test more fully than did the entities in Rose Hill, Brookcrest, or Henry Ford Continuing Care, with their provision of services to a limited "in-house" clientele.

(ii) Preventative Medicine. Wexford physicians (and physicians in comparable facilities) engage in preventative medicine, in the form of immunizations; blood pressure screening; cholesterol testing; glucose and diabetes screening; hemoglobin screening and breast cancer screening; prenatal care; well baby visits and routine physical examinations; general counseling on health, baby care

and basic safety; instruction on self-exams for cancer; and treatment of venereal disease, head lice, scabies and influenza.

In Rose Hill the claimant operated a psychiatric facility, and in Brookcrest and Henry Ford Continuing Care, the claimants operated nursing homes. None of these facilities would seem to provide much preventative care. Accordingly, Wexford is more deserving of exemption than those entities accorded exemption in Rose Hill, Brookcrest, or Henry Ford Continuing Care.

(iii) Health Education. Wexford physicians and staff engage in a significant amount of health education, including distribution of educational materials and the conduct of educational presentations. The Clinic also seems to provide more significant health education than was provided at the exempt nursing homes in Brookcrest, or Henry Ford Continuing Care.

(iv) Communicable Disease Control. Wexford physicians actively engage in communicable disease control at the Clinic, providing immunizations to prevent such diseases, and treating all manner of communicable diseases, ranging from sexually transmitted diseases to scabies, head lice, and influenza. The Clinic seems to provide more significant communicable disease control than was provided at the exempt facilities in Rose Hill, Brookcrest, or Henry Ford Continuing Care.

(v) Social and Sanitary Sciences. It is not entirely clear what is meant by "social and sanitary sciences". The terms are not defined in Rose Hill, and would seem susceptible to different interpretations. While Wexford does not use the Clinic to engage in sanitary sciences, such as water purification or sewage treatment, it engages in social sciences when its physicians provide counseling and educational services, and its professionals follow sanitary protocols in caring for patients. Wexford satisfies this standard as well as those exempted in Rose Hill, Brookcrest or Henry Ford Continuing Care.

(vi) Rose Hill Summary. The Clinic is engaged in significantly more public health activity than were the entities in Rose Hill, Brookcrest or Henry Ford Continuing Care. The Clinic

provides preventative health care (such as screenings, physical examinations and immunizations), communicable disease control (such as immunization and treatment) and health education (through counseling and distribution of literature). The persons who receive treatment at the Clinic can be assumed to circulate widely through society, and thereby some of the benefits they receive will extend to others in the community. And the Clinic provides these services to all, without regard to ability to pay. In light of all of the public health services rendered by the Clinic, and the fact that the Clinic accepts all patients without regard to their ability to pay, it is entitled to exemption under MCL 211.7r.

e. **Typical Family Medical Practice: Butterworth and ProMed**. Here, and in Butterworth, *supra*, and ProMed, *supra*, exemption was sought for property used by a family medical practice operated by a nonprofit hospital. Essentially, it seems was that exemption was denied because the subject property continued to be used for a family medicine practice, which was felt inconsistent with operating for "public health purposes" within the meaning of MCL 211.7r. This conclusion is not persuasive, for several reasons.

(i) American Public Health System. The lower courts erroneously discounted the absolutely critical role that the "typical family medicine practice" plays in the American public health system. To appreciate the importance of this misunderstanding, it is necessary to have some understanding of the American public health system.

The American public health system consists of a multitude of different types of organizations, some of which are governmental, some of which are public charities or educational institutions, and some of which are private health-care providers. At the top, are various governmental entities and medical associations which set forth in broad terms policy goals and statements and which coordinate the provision of care through the dissemination of the data which they collect and analyze. One level down are major health-care providers such as hospitals, nursing homes and similar large

institutions. Some of these are governmental, some are charitable and some are for profit. Next, in the trenches, are the clinicians, those practitioners who come into frequent contact with individual patients. This group includes a "typical family medicine practice". The importance of clinicians to the American public health system cannot be overstated, and the clinician has been recognized as a critical component of the system by the governmental entities which form the peak of the public health system. For each aspects of public health as defined under the Rose Hill/ProMed, *supra*, definition -- preventative medicine, health education, and communicable disease control -- family practitioners are critical.

Preventive services are frequently divided into screening tests, immunizations, and counseling for risk reduction (which can also be called education). *See Guide to Clinical Preventive Services, 2d Ed.* (Washington, D.C.: U.S. Preventive Services Task Force, U.S. Dept. of Health and Human Services, 1996) (henceforth, "*Preventive Services*") (excerpts attached as Exhibit M). In *Preventive Services*, page ix, the authors highlight that:

> "Primary care clinicians have the key role in screening for many of these problems [cardiovascular and infectious diseases, cancers, injuries, alcohol and other drug abuse, etc.] and immunizing against others. Of equal importance, however, is the clinician's role in counseling patients to change unhealthful behaviors related to diet, smoking, exercise, injuries, and sexually transmitted diseases". (Emphasis added.)

Similarly, at page v of *Preventive Services*, the Task Force states that it "remains extraordinarily important that physicians and other providers educate their patients about these matters [tobacco use, poor diet, lack of physical activity and alcohol use]". (Emphasis added.) And, again, at page ix of *Preventive Services*, the Task Force points out that "the majority of deaths among Americans below age 65 are preventable, many through interventions best provided in a clinician's office". (Emphasis added.) Thus, according to the Task Force, the primary care clinicians have a "key role" in the

"extraordinarily important" public health areas of screening, immunizations and counseling, and that public health intervention is, in many instances, "best provided" in a clinician's office. Clearly, then, the "typical family medicine practitioner" is an absolutely critical feature of America's preventive medicine system, and, accordingly, its public health system.

Similarly, the *Community Guide for National Infant Immunization Week*, (Atlanta, GA: Centers for Disease Control and Prevention, 1999) (henceforth, the "*Community Guide*") (excerpts attached as Exhibit N), contains a section "geared toward health-care providers who are in the best position to reach parents and caregivers", who, from context, are family practitioners. (Emphasis added.) The *Community Guide* then describes as "vital" to a community's immunization effort the "awareness, endorsement, and participation of many kinds of health-care providers -- such as pediatricians, family practitioners", etc. (Emphasis added.) Thus, according to the *Community Guide*, the role of the family practitioner in the public health area of immunization is described as "vital", and family practitioners may be in the "best position" to promote immunization among children.

Concerning infectious diseases in general, *Addressing Emerging Infectious Disease Threats: A Prevention Strategy for the United States* (Atlanta, GA: Centers for Disease Control and Prevention, 1994) (excerpt attached as Exhibit O describes the "Critical Role of Partnerships" and says:

> "Effective public health policy results from interaction, cooperation, and coordination among a wide range of public and private organizations and individuals. Particularly critical to this process are CDC's partnerships with state and territorial health departments; other federal agencies; professional organizations; academic institutions; private health-care providers; health maintenance organizations and health alliances; local community organizations; private industry; and international partners, including WHO and international service organizations and foundations. Each of these partners will play an integral role in the cooperative efforts required to safeguard the public's health from emerging infectious disease threats". (Emphasis added.)

The upshot of all this is clear: the lower courts took an overly narrow view of which entities might properly be considered to be engaged in promoting the public health. The typical family medical practice is, in fact, a vital, integral component of the public health system and is generally in the best position to undertake critical public health measures such as education, screening, immunization and communicable disease control. Rather than precluding exemption under the public health exemption, characterization as a typical family medical practice ought to form the basis for and provide support for a claim for public health exemption.

(ii) Statute Does Not Preclude Exemption for Typical Family Practices. The language of MCL 211.7r, which provides for the public health exemption does not preclude exemption for a typical family medicine practice, and such preclusion should not be inferred. Saginaw General Hospital v City of Saginaw, 208 Mich App 595, 600; 528 NW2d 805 (1995), involved exemption for a child care center. The court granted exemption, stating, "The Legislature has not acted to exclude on-site child care from tax exempt status. The Tax Tribunal should not add exclusions, but should faithfully apply the statutory test." 298 Mich App at 500.

Moreover, it would be wholly inappropriate to "carve out" a new exception to exemption for nonprofit entities which (arguably) have "commercial counterparts." This argument was rejected in Hospital Purchasing Service of Michigan v Hastings, 11 Mich App 54; 393 NW2d 568 (1986), and its even-handed application would require taxation of a myriad of nonprofit entities which have commercial counterparts, ranging from universities to theatres to scientific research labs to pre-schools to youth summer camps. The University of Phoenix, Inc., one of the largest universities in the nation, is for-profit; does that mean Kalamazoo College should lose its tax exemption?

(iii) Promotion of an Individual's Health Can Promote Public Health. MCL 211.7r provides property tax exemption to otherwise qualifying entities which operate for a

"public health purpose". Of late, lower courts considering the Public Health Exemption have labored under the misperception that public health generally is not promoted where health care is provided on an individual basis by a physician, rather than to a mass public. This interpretation overlooks the manner in which public health is provided, and it ignores Michigan case law, discussed above, concerning the public health exemption.

"Public health" often is enhanced through the promotion of a single individual's health, and the public health system generally treats individual patients one at a time. Many of the health promoting activities undertaken by family care physicians are not mutually exclusive to either the public health world or the private practice world. There are a few public health activities, such as water purification, which function most effectively on a mass, non-individualized basis, but for most purposes the public health is promoted most effectively in a one-on-one physician-patient relationship. Indeed, numerous activities undertaken by the public health departments are in fact undertaken on an individualized basis, and not in a group context. These activities included hearing tests, blood tests, blood pressure testing, cholesterol testing, and numerous others.

Many of the Clinic's activities which promote public health are more appropriately provided on an individual basis by a private physician rather than *en masse* or through a government health department. For example, consider the crucial public health function of immunization. In Michigan, 60 to 65 percent of all vaccines are being delivered by the non-government "private" sector, while only 35 to 40 percent are delivered by government units, and concentrating care in the private sector has improved immunization records. Testimony of Gary L. Freed, M.D., M.P.H., Percy and Mary Murphy Professor of Pediatrics and Child Health Delivery at the University of Michigan, in McLaren Regional Medical Center v Owosso, MTT 268590 (Sept. 27, 2002)

(excerpt attached as Exhibit P). Thus, the critical, and indisputably "public health," function of immunization is dominated by the non-government sector.

The existence of a "single medical home" for both curative care and preventive care is both a convenience to the patient and a beneficial mechanism by which to deliver preventive care, and, as a result, government units have sought to devolve delivery of those preventive services to the individual physician practices. The American Pediatric Association has called providing each child with a medical home one of its "essential child health outcomes for the 21st century." *See, e.g.*, Sia, Tonniges, Osterhaus & Taba, *History of the Medical Home Concept*, 114 Pediatrics 1473, 1473 (May , 2004) (attached as Exhibit Q). Thus, it is clear that private family practitioners have responsibility for a large and increasing portion of the public health function. The idea that family practitioners are not part of the public health system, or that they do not promote public health, is simply wrong.

Moreover, Michigan cases which have allowed exemption under the public health exemption have not been limited to entities which provide mass health services through public agencies. For example, in Rose Hill, a residential psychiatric treatment center was deemed to be used for public health purposes, although its services were to a small group of individual patients. In Brookcrest and Henry Ford Continuing Care, the Tribunal awarded exemption to a nursing home under the public health exemption. Again, a private nursing home provides individual care to individual patients.

(vi) Private Practices Distinguished. Private practices often do not provide care to patients who are unable to pay. In 1999, the Michigan State Medical Society found that only 57 percent of physicians provided any charity care in their practices (*see*, Campbell, *1999 MD Data Survey on Practice Characteristics*, 98 Michigan Medicine 20 (June, 1999) at p. 30 (hereafter, the "*MSMS 1999 Survey*") (attached as Exhibit R)), and the *MSMS 2005 Survey*, *supra* at p.

16, reveals that only 62 percent of physicians provide charity care. The *MSMS 1997 Survey, supra* at p. 39, indicates that only 58 percent of physicians accept new Medicaid patients without limits; the *MSMS 2005 Survey, supra at 15, 13 & 16* shows that 65 percent of physicians participate in Medicaid plans, but 18 percent of physicians "do not intend to continue accepting Medicaid patients in the coming year." Since, as discussed above ten to fifteen percent of physicians are employed by charitable hospitals or by university/teaching hospitals, and would very likely be required to provide such care, it seems likely that most "purely" private physicians provide no charity care (and even those that provide some charity care may still be turning away some prospective charity care patients) and do not accept new Medicaid patients without limits.

4. No Erosion of Tax Base. Lower courts considering tax exemption in the healthcare field have sometimes expressed concern that granting exemption would induce commercial healthcare providers to convert to nonprofit status, and thereby undermine the tax base of local governments. This is not a realistic concern.

As an initial matter, any healthcare business which converted to nonprofit status would, in accordance with State nonprofit corporation law discussed above, be prohibited from engaging in operations "involving pecuniary gain or profit for its officers, directors, shareholders or members." MCL 450.2251(1). That prohibition, by itself, would eliminate any serious threat to tax bases.

In addition, in order to promote "public" health in a charitable manner, a provider would have to provide health to all members of the public, without regard to their ability to pay. As discussed above, most commercial providers do not even accept Medicaid without restriction.

Finally, this Court may note that federal income taxation (along with state single business tax, exemption under which is directly tied to federal income tax exemption) is for most taxpayers a much larger burden than is state property taxation, and, as mentioned above, the Internal Revenue Service

recognizes that the promotion of health may provide the basis for federal income tax exemption. It seems clear that federal income tax exemption is available for many nonprofit healthcare providers. If the fear of a devastated tax base had any basis in fact, one would expect that federal income taxation, state single business taxation and sales and use taxation would already have driven healthcare providers to convert to nonprofit status, and Michigan would by now be devoid of taxable healthcare providers. Yet, there still exist in Michigan thousands of healthcare providers, ranging from physician practices to CT scanners, who are taxable for federal (and state) tax purposes. That is ample evidence that the burdens associated with tax exemption far outweigh the benefits for the great majority of taxpayers. And that will not change even if property is exempted from tax.

5. **Construction of Exemption: Target of Public Health Exemption**. It is conceivable that the lower court's narrow view of what entities operate for a public health purpose might be justified in light of the standard rule that tax exemptions are to be construed against the party claiming exemption. However, the context of the public health exemption does not support such a narrow reading. As discussed above, the public health system consists of governmental entities and professional associations, hospitals and other institutions and physicians, including clinicians. If the exemption is not intended to include family practices, what is it intended to include?

The public health exemption is not aimed at governmental entities, such as the Department of Community Health; state and federal entities are exempt under other provisions of the property tax laws and do not need another exemption. Nor is it aimed at large professional organizations such as the American Medical Association. Those types of organizations are frequently trade associations and would therefore likely not be considered nonprofit trusts within the meaning of the public health exemption. Nor is it aimed at hospitals, since hospitals are specifically referred to in the statute.

Finally, it is not aimed at for profit entities, such as self-employed physicians, pharmacies, or for profit laboratories, since these entities would not be considered nonprofit trusts.

That means that the exemption can only be aimed at health care providers which are: 1) Not governmental entities; 2) Not trade associations; 3) Not hospitals; and 4) Not for-profit businesses. An operation like the Clinic is, therefore, a member of a fairly narrowly defined class of enterprises that could, conceivably, be the intended beneficiaries of the exemption statute. Narrow construction does not mean construction that precludes exemption for members of one of the few potential beneficiaries of the exemption.

6. **Summary: Public Health Exemption**. Under any approach, the Clinic is operated for public health purposes and satisfies the three tests for exemption set forth in MCL 211.7r. Here, Wexford owns and occupies the Clinic, uses the Clinic to promote public health by providing preventive medicine, communicable disease control and health education. The Clinic is also public in the sense that it accepts all patients without regard to their ability to pay. The Clinic may share some characteristics with a "typical family medical practice". However, this similarity should not defeat exemption.

D. LEVEL OF CHARITABILITY. Courts have not imposed a threshold level of charitability in determining that property is used for charitable purposes. In Michigan Sanitarium, 138 Mich at 683-684, the Court ruled that a sanitarium was "sufficiently charitable to entitlement to [exemption] when the charges collected for services are not more than are needed for its successful maintenance." The Court expressly rejected the taxing authority's argument that the trial court erred "in refusing to permit [the taxing authority] to show the number of operations in [claimant's] sanitarium that were paid for". The Michigan Sanitarium court believed that the quantity of free services was irrelevant. Under this analysis the Clinic would qualify as being used for charitable purposes within the meaning of MCL 211.7o.

E. **CONCLUSION**. Michigan law provides property tax exemption for property which is owned and occupied by qualifying nonprofit entities for public health or charitable purposes. Facilities like the Clinic are essential components of the public health system, especially in rural areas with limited access to health care. Facilities like the Clinic provide a valuable gift to the community. As discussed above, the Property qualifies for exemption under both of these statutory exemptions.

RELIEF REQUESTED

MRHCO respectfully requests that the Court issue an order stating that the Property is exempt from taxes under MCL 211.7o, MCL 211.9(a) (for personal property) and MCL 211.7r.

Respectfully submitted,
Michigan Rural Health Clinics Organization

BY: E. William Shipman by consent

E. WILLIAM SHIPMAN (P36143) CLD
Butzel Long, P.C.
150 W. Jefferson Avenue, Suite 100
Detroit, MI 48226
(313) 983-7461

Dated: July 7, 2005